Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA RD
PASADENA TX 77504-2117

Respondent Name
NETHERLANDS INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 1

MFDR Tracking Number
M4-10-2401-01

MFDR Date Received
January 7, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is unclear from the Explanation of Benefits what methodology Carrier used to calculate reimbursement, but because Provider does request that the implantables be paid separately, Carrier should have reimbursed Provider pursuant to section 134.403(f)(1)(A). Carrier has severely under-reimbursed Provider by either applying the inappropriate reimbursement methodology or inappropriately calculating reimbursement under the applicable rule."

Amount in Dispute: $8,102.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier does not concede that the fees in dispute are in accordance with applicable fee guidelines. The carrier has paid appropriately."

Response Submitted by: Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 12, 2009	Outpatient Hospital Services	$8,102.44	$4,762.60

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.

4. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective review of health care.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. FEE GUIDELINE MAR REDUCTION.
   - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. IMPLANTS IN AND ASC REQUIRE CERTIFICATION PER RULE 134.402.
   - 150 – PMT ADJUSTED BECAUSE THE PAYER DEEMS THE INFO SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE. DOCUMENTATION REQUIRED TO REVIEW BILL.
   - 198 – PAYMENT DENIED/REDUCED FOR EXCEEDED PRECERTIFICATION/AUTHORIZATION.
   - 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE. UNBUNDLING – INCLUDED IN ANOTHER BILLED PROCEDURE.

Issues

1. Were the services in dispute preauthorized?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. What is the additional recommended payment for the implantable items in dispute?
6. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed surgical services billed under procedure codes 29882 and 20926 with reason code 198 – "PAYMENT DENIED/REDUCED FOR EXCEEDED PRECERTIFICATION/AUTHORIZATION." Per 28 Texas Administrative Code §134.600(c)(1), effective May 2, 2006, 31 *Texas Register* 3566, the carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) only in the case of an emergency or "preauthorization of any health care listed in subsection (p) . . . that was approved prior to providing the health care." §134.600(p)(2) states that the non-emergency health care requiring preauthorization includes "outpatient surgical or ambulatory surgical services." Review of the preauthorization letter finds that neither CPT code 29882 nor 20926 are listed among the approved procedure codes. No documentation was found to support a medical emergency, nor was any documentation found to support that these services had been preauthorized. The insurance carrier's denial reason is supported. Reimbursement for procedure codes 29882 and 20926 cannot be recommended.
2. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). The facility's total billed charges for the separately reimbursed implantable items are $3,540.00. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments below.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website.

Reimbursement for the disputed services is calculated as follows:

- Procedure code J3490 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code A4649 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code A4649 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 85014 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.46. 125% of this amount is $4.33
- Procedure code 29888 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. The requestor billed procedure code 29888 with modifier 22. Review of the submitted information found insufficient documentation to support the use of this modifier. These services are classified under APC 0042, which, per OPPS Addendum A, has a payment rate of $3,251.11. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,950.67. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $1,914.78. The non-labor related portion is 40% of the APC rate or $1,300.44. The sum of the labor and non-labor related amounts is $3,215.22. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.246. This ratio multiplied by the billed charge of $2,143.50 yields a cost of $527.30. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $3,215.22 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is $13,621.15. The allocated portion of packaged costs is $13,621.15. This amount added to the service cost yields a total cost of $14,148.45. The cost of these services exceeds the annual fixed-dollar threshold of $1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is $8,521.81. 50% of this amount is $4,260.91. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is $7,476.13. This amount multiplied by 130% yields a MAR of $9,718.97.
- Procedure code 29876 is unbundled. This procedure is a component service of procedure code 29888 performed on the same date. Payment for this service is included in the payment for the primary procedure. Per Medicare policy, these two codes may not be reported on the same date of service unless an appropriate modifier is appended to the component code to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with a modifier; however, review of the submitted medical documentation finds that the modifier is not supported. Separate payment is not recommended.
- Procedure code 94762 has a status indicator of Q1, which denotes STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date. Separate payment cannot be recommended.
- Procedure code 94760 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

5. Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." Review of the Implant/Prosthesis Record and other submitted documentation finds that the separate implantables include:
   - "DEVICE MAXFIRE" as identified in the itemized statement and labeled on the invoice as "Maxfire meniscal device with ZipLoop" with a cost per unit of $382.00 at 2 units, for a total cost of $764.00.

- Per §134.403(b)(2), "Implantable" means an object or device that is surgically: (A) implanted, (B) embedded, (C) inserted, (D) or otherwise applied, and (E) related equipment necessary to operate, program and recharge the implantable. The health care provider billed for a “MAXCUTTER" as identified in the itemized statement and labeled on the invoice as "2.33 mm disposable Maxcutter," and a “CENTRIFUGE SEPARATOR" as identified in the itemized statement and labeled on the invoice as "2.33 mm disposable Maxcutter;" Review of the Implant/Prosthesis Record and other submitted information finds insufficient documentation to support that these items were implanted or meet the definition of an implantable under §134.403(b)(2). Separate reimbursement is not recommended.
- Review of the Implant/Prosthesis Record finds that the health care provider also implanted two RC Loop (DS) Anchors with Orthocord(s). Review of the accompanying invoice finds that the order date and shipping date for the items listed was after the date of the surgery. Further, the lot/serial number of the item(s) on the provided invoice does not match the serial number of the items that were listed as implanted. Review of the submitted information finds insufficient documentation to establish the manufacturer’s invoice amount or the net amount (exclusive of rebates and discounts) for the purpose of determining the reimbursement amount for these disputed items. Separate reimbursement cannot be recommended.

The total net invoice amount (exclusive of rebates and discounts) is $764.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $76.40. The total recommended reimbursement amount for the implantable items is $840.40.

6. The total allowable reimbursement for the services in dispute is $10,563.70. This amount less the amount previously paid by the insurance carrier of $5,801.10 leaves an amount due to the requestor of $4,762.60. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $4,762.60.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4,762.60, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	June 14, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.